What is the KidsWell School-Based Health Center?

KidsWell provides healthcare to children in the school setting in-person or via telemedicine. Services include:

- Sick visits
- Chronic illness management such as asthma
- ADHD management

How do I sign up?

- Complete the consent forms
- Schedule appointment through the school nurse

What about Insurance?

- SC Medicaid covers the visits
- Private insurance coverage varies and copays and deductibles apply

For questions, call your school nurse or the KidsWell team at 843-754-7670 or 843-609-9317.

In collaboration with

Charleston Promise Neighborhood
Transformation Within A Generation

Charleston County SCHOOL DISTRICT
excellence is our standard

SOUTH CAROLINA Telehealth ALLIANCE

musc Children's Health
Medical University of South Carolina

MUSChealth.org/telehealth-schools

843-792-3227

School-Based Health Enrollment Forms

We are so excited to offer the School-Based Health Program in your child's school! There are **three places for you to sign** to enroll your child in the program:

Form Name	Purpose
Consent for Treatment	Signing this form allows your child **to receive medical care in the school.**
Authorization to Disclose Protected Health Information	**This form allows the health care team to work with the school.** Signing this form allows the healthcare providers, the school nurse, and your child's main healthcare provider share medical information about your child's health.
Consent for Release of Education Records and Information	**This form allows the school to work with the healthcare team.** Signing this form allows the school to share medical, psychological and other personal information about your child with the healthcare provider.

If you have any additional questions, please contact your school nurse or the School-Based Health Program at (843) 792-3227 or schoolbased@sctelehealth.org.

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If you do not wish to participate in the program, check the box below and return this page to your school nurse.

□ I do not wish to participate in the School-Based Health program.

Print

Print Completed Form and Reset

Reset

SOUTH CAROLINA Telehealth ALLIANCE

BILLINSUR

School-Based Health Clinic Patient Demographic Form

Form Origination Date: 11/13
Version: 3

Version Date: 4/18

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Grade: _____ Teacher Name: _____

Patient Name _____ _____ _____
Last First Middle

Patient Birth Date: _____ Age: _____ Primary Language: ☐ English ☐ Spanish ☐ Other _____

Sex: ☐ Male ☐ Female Social Security Number: _____

Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Multiracial ☐ Other: _____

Primary Care Provider _____

Parent or Guardian Name _____

Relationship to Patient _____

Parent or Guardian Birth Date _____

Parent or Guardian Social Security Number _____

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

List the name and contact information of a person (or persons) we can contact if parents/guardian cannot be reached.

Emergency Name & Number _____

Relationship to Patient _____

Emergency Name & Number _____

Relationship to Patient _____

PROVIDE PATIENT INSURANCE INFORMATION.
Include a copy of the front & back of your Medicaid/Insurance card.

☐ 1. Medicaid Number _____
Medicaid Plan: _____

☐ 2. Private medical health insurance:
Name _____
Policy # _____

Who (name) insures child? Relationship to insured child _____
Employers Name: _____

☐ 3. No Insurance.

Print | Print Completed Form and Reset | Reset

SOUTH CAROLINA Telehealth ALLIANCE

SCHOOLCONST

School-Based Clinic Consent for Treatment

Patient Name_____
MRN _____
PATIENT IDENTIFICATION LABEL

Form Origination Date: 11/13
Version: 6 Version Date: 4/18

Student Name:_____

I give my consent for my child, named above, to receive medical care from the School-Based Health Program. Care will be provided in a private manner and information will not be released without my consent. I allow physicians or designated health professionals to provide necessary and/or advisable treatment for my child and to bill for this service. I understand that supervised residents and students may assist in my child's care. I understand that my child may receive medical care from providers who are authorized by my child's school district.

I authorize the holder of medical or other information about me to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid or third party claims.

I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles. I understand this consent form is valid, until I revoke it.

I received a copy of a "Notice of Privacy Practices" from providers who are authorized by my child's school district and/or a copy of the MUSC "Notice of Privacy Practices".

_____ _____
Signature of Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

PRINT PRINT COMPLETED FORM & RESET RESET

SOUTH CAROLINA Telehealth ALLIANCE

SCHOOLCONST

Patient Name_____

SCHOOL-BASED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Form Origination Date: 11/13
Version: 5 Version Date: 8/18

MRN _____
PATIENT IDENTIFICATION LABEL

Patient Name:_____

All healthcare information is private. By signing this form, you are giving the school clinic, the school nurse, and the student's main health care provider consent to speak with and share medical information about the student's health with providers who are contracted to provide care in the school-based health program as needed. This information will be treated in a confidential way.

The purpose of the disclosure is: participation in school-based health services

Examples of protected health information that may be shared include but are not limited to

- medical history (including any medical diagnosis and treatment),
- physical examinations,
- consults,
- lab reports,
- and a list of current medications.

I understand this information may include references to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV /AIDS and / or alcohol abuse.

I understand that this information may be exchanged by mail, fax, email, phone, or a secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the School-Based Health Program office. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice. I understand this consent form is valid until I revoke it.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.

_____ _____
Signature of Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

_____
Relationship to Patient

To contact the South Carolina Telehealth Alliance School-Based Health Program office, in writing, the address is 169 Ashley Avenue MSC 332 Charleston, SC 29425; the phone number is (843) 876-0240.

CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

The _____ (the District) shall obtain written consent before disclosing any personally identifiable information from an education record. I understand that the District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to representatives of the School-Based Health program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked). I understand this consent form is valid until I revoke it.

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected by the requirements of the FERPA.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Signature of Parent/Guardian/Surrogate Parent Date

To contact the South Carolina Telehealth Alliance School-Based Health Program office, in writing, the address is 169 Ashley Avenue MSC 332 Charleston, SC 29425; the phone number is (843) 876-0240.

SOUTH CAROLINA
Telehealth
ALLIANCE

FAQs – Frequently Asked Questions about the School-Based Telehealth Program

What is the School-Based Telehealth program?
Your child may have the opportunity to participate in a school-based telehealth visit. The program is used to bring healthcare to children in the school setting. A nurse practitioner or a doctor examines your child with the assistance of the school nurse. Computers and monitors are used so that patients and providers can see each other, talk clearly, and share information. At times special equipment, like electronic stethoscopes and a camera to look inside a child's ears are used.

Who will be participating in the telehealth visit?
Individuals, such as the school nurse, will be present to operate the video equipment. They will take reasonable steps to maintain confidentiality of the information obtained.

How will information collected from the telehealth visit be used?
Medical information from your child's medical chart will be used for reports and to evaluate the school-based telehealth program, but your child will not be identified with this information. The video session is not recorded but some elements such as pictures may be taken. These materials will be maintained as a confidential medical record.

Is there any other information I should know?
You and your child have the right to ask the healthcare provider to discontinue the conference at any time. In addition, some parts of the exam may be conducted by the school nurse, or medical assistant, under the guidance of the healthcare provider who is evaluating the child.

NOTICE OF PRIVACY PRACTICES

MUSC Organized Health Care Arrangement (OHCA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

The Medical University of South Carolina and its affiliates (including but not limited to the Medical University Hospital Authority, MUSC Physicians, MUSC Physicians Primary Care, MUSC Health Partners, MUSC Health Alliance, MUSC Strategic Ventures, LLC, and MUSC Strategic Ventures (MSV) Health, Inc.) participate in a clinically integrated health care setting. As a result of this clinical integration, these organizations function as an Organized Health Care Arrangement (OHCA) as defined by the Health Insurance Portability and Accountability Act (HIPAA). For purposes of this notice, the members of the MUSC OHCA are collectively referred to in this document as "MUSC." **We collect, receive, or share this information about your past, present or future health condition to provide health care to you, to receive payment for this health care, or to operate the hospital and/or clinics.**

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

MUSC is committed to protecting the privacy of health information we create and obtain about you. This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information. We are required by law to: (i) make sure your health information is protected; (ii) give you this Notice describing our legal duties and privacy practices with respect to your health information; and (iii) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI) –

A. The following uses do NOT require your authorization, except where required by SC law:

1. For treatment. Your PHI may be discussed by caregivers to determine your plan of care. For example, the physicians, nurses, medical students and other health care personnel may share PHI in order to coordinate the services you may need.
2. To obtain payment. We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party. For example, we may use the information to send a claim to your insurance company.
3. For health care operations. We may use and disclose PHI for hospital and/or clinic operations. For example, we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. Business Associates. Your medical information could be disclosed to people or companies outside our Health System who provide services. These companies typically are required to sign special confidentiality agreements before accessing your information. They are also subject to fines by the federal government if they use/disclosure your information in a way that is not allowed by law.
5. For public health activities. We report to public health authorities, as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
6. Victims of abuse, neglect, domestic violence. Your PHI may be released, as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspected.
7. Health oversight activities. We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
8. Judicial and administrative proceedings. Your PHI may be released in response to a subpoena or court order.
9. Law enforcement or national security purposes. Your PHI may be released as part of an investigation by law enforcement or for continuum of care when in the custody of law enforcement.
10. Military and Veterans. If you are a member of the U.S. or foreign armed forces, we may release your medical information as required by military command authorities.
11. Uses and disclosures about patients who have died. We may provide medical information to coroners, medical examiners and funeral directors so they may carry out their duties.
12. For purposes of organ donation. As required by law, we will notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
13. Research. We may use and disclosure your medical information for research purposes. Most research projects are subject to Institutional Review Board (IRB) approval. The law allows some research to be done using your medical information without requiring your written approval.
14. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.
15. For workers compensation purposes. We may release your PHI to comply with workers compensation laws.
16. Marketing. We may send you information on the latest treatment, support groups, reunions, and other resources affecting your health.
17. Fundraising activities. We may use your PHI to communicate with you to raise funds to support health care services and educational programs we provide to the community. You have the right to opt out of receiving fundraising communications with each solicitation.
18. Appointment reminders and health-related benefits and services. We may contact you with a reminder that you have an appointment.
19. Disaster Relief Efforts. We may disclose your medical information to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses or disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

B. You may object to the following uses of PHI:

1. Inpatient hospital directories. Unless you tell us not to, we may include your name, location, general condition and religious affiliation in our patient directory so your family, friends and clergy can visit you and know how you are doing.

2. Information shared with family, friends or others. Unless you tell us not to, we may release your PHI to a family member, friend, or other person involved with your care or the payment for your care.
3. Health plan. You have the right to request that we not disclose certain PHI to your health plan for health services or items when you pay for those services or items in full.

C. Your prior written authorization is required (to release your PHI) in the following situations:

You may revoke your authorization by submitting a written notice to the privacy contact identified below. If we have a written authorization to release your PHI, it may occur before we receive your revocation.
1. Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.
2. Mental Health Records unless permitted under an exception in section A.
3. Substance Use Disorder Treatment records unless permitted under an exception in section A.
4. Any circumstance where we seek to sell your information.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Although your health record is the physical property of MUSC, the information belongs to you, and you have the following rights with respect to your PHI:
A. The Right to Request Limits on How We Use and Release Your PHI. You have the right to ask that we limit how we use and release your PHI. We will consider your request, but we are not always legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) the information you want to limit; (2) whether you want to limit our use, disclosure or both; (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) an expiration date**.**
B. The Right to Choose How We Communicate PHI with You. You have the right to request that we communicate with you about PHI and/or appointment reminders in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted. We will accommodate reasonable requests.
C. The Right to See and Get Copies of Your PHI. You have the right to inspect and/or receive a copy (an electronic or paper copy) of your medical and billing records or any other of our records used to make decisions about your care. You must submit your request in writing. If you request a copy of this information, we may charge a cost-based fee. MUSC will act on a request for access or provide a copy usually within 30 days of receipt of the request. We may deny your request in limited circumstances. If you are denied access to your records, you may request that the denial be reviewed by a licensed health care professional. Additionally, we may use and disclose information through our secure patient portal which may allow you to view and communicate with certain health care providers in a secure manner. For more information see our https://mychart.musc.edu/mychart/
D. The Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI. This list may not include uses such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory as described above in this Notice of Privacy Practices. This list also may not include uses for which a signed authorization has been received or disclosures made more than six years prior to the date of your request.
E. The Right to Amend Your PHI. If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or if it originated in another facility's record. Notification will be provided within 60 days.
F. The Right to Receive a Paper or Electronic Copy of This Notice: You may ask us to give you a copy of this Notice at any time. For the above requests (and to receive forms) please contact: Health Information Services (Medical Records), Attention: Release of Information / 169 Ashley Avenue / MSC 349 / Charleston, SC 29425. The phone number is (843) 792-3881.
G. The Right to Revoke an Authorization. If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This revocation will stop any future release of your health information except as allowed or required by law.
H. The Right to be Notified of a Breach. If there is a breach of your unsecured PHI, we will notify you of the breach in writing.

HEALTH INFORMATION EXCHANGES

MUSC, along with other health care providers, belongs to health information exchanges. These information exchanges are used in the diagnosis and treatment of patients. As a member of these exchanges, MUSC shares certain patient health information with other health care providers. Should you require treatment at another location that is a part of one of these exchanges, that provider may gather historical health information to assist with your treatment. You have the option of saying that this cannot be done. If you choose not to take part in these alliances, please contact the MUSC Privacy Office at 792-4037.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this Notice. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality health care in a confidential and private environment.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices please call the Privacy Officer (843) 792-4037, the Privacy Hotline (800) 296-0269, or contact in writing: HIPAA Privacy Officer / 169 Ashley Avenue / MSC 332 / Charleston SC 29425. You also may send a written complaint to the U.S. Dept. of Health and Human Services, Office for Civil Rights. The address will be provided at your request or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time. The changes will apply to all existing PHI we have about you.. This Notice will always contain the effective date and may be reviewed at http://academicdepartments.musc.edu/musc/about/compliance/privacy.html

EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on April 14, 2003 and was last revised on August 2018.